Palouse River Counseling
340 N.E. Maple St, Pullman, WA 99163 (509) 334-1133

INSURANCE COMPANY / POLICY HOLDER
CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ of _____

_____

_____
(Address)

authorize Palouse River Counseling to mutually exchange with:

_____
(Name of the person or organization to which disclosure is to be made)

the following information: **Diagnosis, Chart Notes, Dates of Service, Demographic Information, Discharge Summary, Assessments and Evaluations, ASAM Level of Care ___**

_____

_____

Purpose: **Receive payment for services rendered.**_____
_____

_____

I understand that my records are protected under the Federal and State confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for under part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of drug and alcohol treatment records. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event, this consent expires automatically as described below.

Specification of the date, event, or condition upon which this consent expires:

90 Days from date of discharge

I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

Executed this _____ day of _____, 20___.

_____ _____
(Signature of participant) (Signature of parent/guardian if client is under 14 y.o.)